EXHIBIT “A”

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

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HONORABLE HERNÁN D. VERA, DISTRICT JUDGE PRESIDING

MARK SNOOKAL, Plaintiffs, vs. CHEVRON USA, INC., Defendants.	No. CV 23-06302-HDV

REPORTER'S TRANSCRIPT OF PARTIAL JURY TRIAL PROCEEDINGS

TRIAL DAY ONE

LOS ANGELES, CALIFORNIA

TUESDAY, AUGUST 19, 2025

MARIA R. BUSTILLOS
OFFICIAL COURT REPORTER
C.S.R. 12254
UNITED STATES COURTHOUSE
350 WEST 1ST STREET
SUITE 4455
LOS ANGELES, CALIFORNIA 90012
(213) 894-2739
MADAMREPORTER.COM

A P P E A R A N C E S

ON BEHALF OF THE PLAINTIFFS, MARK SNOOKAL:

ALLRED MAROKO and GOLDBERG
BY: DOLORES Y. LEAL, ESQ.
6300 WILSHIRE BOULEVARD
SUITE 1500
LOS ANGELES, CA 90048
(323)653-6530

ALLRED MAROKO and GOLDBERG
BY: OLIVIA J. FLECHSIG, ESQ.
6300 WILSHIRE BOULEVARD
SUITE 1500
LOS ANGELES, CA 90048
(323)653-6530

ON BEHALF OF THE DEFENDANTS, CHEVRON USA, INC.:

SHEPPERD, MULLIN, RICHTER, and HAMPTON, LLP
BY: ROBERT E. MUSSIG, JR., ESQ.
350 SOUTH GRAND AVENUE
FORTIETH FLOOR
LOS ANGELES, CA 90071
(213)620-1780

SHEPPERD, MULLIN, RICHTER, LLP
BY: TRACEY A. KENNEDY, ESQ.
350 SOUTH GRAND AVENUE
FORTIETH FLOOR
LOS ANGELES, CA 90071
(213)620-1780

I N D E X

PLAINTIFF'S WITNESSES:	DIRECT	CROSS	REDIRECT	RECROSS
DR. MARMUREANU, ALEXANDER	--	--	--	--
BY OLIVIA FLECHSIG	51	--	--	--
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BY DOLORES LEAL	130	--	--	--

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E X H I B I T S (STIPULATED)

PLAINTIFF'S	RECEIVED	MARKED
121	54	--
122	75	--
13	113	--
31	115	--
33	115	--
68	116	--
29	136	--
33	139	--
68	106	--
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E X H I B I T S (STIPULATED)

DEFENSE'S	RECEIVED	MARKED
68	92	--

THE WITNESS: Sorry. Dr. Alex Marmureanu, M-A-R-M-U-R-E-A-N-U.

THE COURT: Very good.

Go ahead, Counsel.

MS. FLECHSIG: Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. FLECHSIG:

Q Doctor, could you start by telling us what you do professionally?

A I'm a thoracic and cardiovascular surgeon.

THE WITNESS: I guess you can hear me; yes? It's loud enough?

THE COURT: Yes, thank you.

THE WITNESS: So I do heart and lung surgery. I do thoracic midchest. Cardiac is heart. And vascular, all the blood vessels except the one in the brain. I'm a surgeon.

BY MS. FLECHSIG:

Q All right. Where do you currently work?

A I practice in seven hospitals in Los Angeles. I'm the chief of cardiothoracic surgery in two hospitals. I have a very busy practice, probably around 300 cases per year, Los Angeles, part of the university. Travel all over the world to give talks and do pro bono cases, as well as teaching.

Q You said you do some teaching. Who do you teach, or what do you teach?

A I teach surgery. I'm board-certified in cardiothoracic surgery, as well as general surgery, which is surgery all over the body. I teach students, residents, fellows, other surgeons, including travel usually once a year, sometimes twice a year all over the world from Italy to Mongolia to Africa to South America to do charity cases and do usually minimally invasive surgery.

Q And what training did you undergo to be able to do that?

A I was born in Romania. My parents were physicians. My sister is a physician too. So I grew up there. I went to medical school in Romania. I did my training -- surgical training in Romania.

THE COURT: Doctor, you're starting to talk a little bit fast. If you could, slow down just a bit.

THE WITNESS: Thank you, sir.

I did my surgical training in Romania. In the early '90s, I was offered a position at New York University. So I had to do my training all over again, déjà vu. So I did my general surgery residency at New York University at Mount Sinai. Then I came to UCLA in 2004, my cardiothoracic surgery fellowship, which is

a training in heart and lung surgery. I've been on faculty for a while. Then I went to private practice. And, again, we have a very busy practice covering seven hospitals: six in Los Angeles, one in Palm Springs.

BY MS. FLECHSIG:

Q This may be an obvious question, by now, but do you hold any board certifications?

A Yes. I am, again, board-certified in cardiothoracic surgery and general surgery.

Q And just to clarify, how long have you been practicing as a cardiothoracic surgeon?

A I think 35 years -- over 30 years, yeah.

Q Okay. Dr. Marmureanu, I handed you an exhibit binder there. If you could, kindly turn to what's been marked as Exhibit 121. Can you -- can you describe this document?

A It's my CV, my resume, curriculum vitae, first page.

Q Okay. Are you familiar with the contents of what's in that CV or resume?

A Very familiar. I wrote it.

Q Is all the content true?

A Yes.

MS. FLECHSIG: Okay. At this time, I offer Exhibit 121 into evidence.

four. When we do a CAT -- the way we measure -- the best studies is called the CT scan, a CT angio. What is an angio? We put contrast. So imagine this would be red. It is much easier for you guys to see the size if it's red or blue or any color in here. So we put contrast, and we see it white. Why is that important? Because when you do a CAT scan, the patient sleeps on the table right here, and you look from your feet up so the multiple -- 120 usually. So you get to see the size of the aorta at all points.

Well, we advise the patients to get the same study in the same place, read by the same radiologist with the same sequence of giving contrast. Why? Because one millimeter could change the whole paradigm or two. Why is that? The way the radiologists measure, they take the cursor on the computer and they put an X in here, put an X in here, click the bottom, and the computer gives them the size.

Now, all that you need is not that clear. If you put the X a little bit here, a little bit here, it is one millimeter. The next thing you know, you miss one millimeter here, one millimeter here, which is not that much. It is 4.2. So you can have 4.0, and it reads 4.2, not a big deal. Why? Because you don't have to do anything. A 4.2, nothing really matters. 4.5,

probably nothing, the same. 4.7, you start wondering. You start saying perhaps you should get the test more often. But if it is over 5, it is actually 5.5. So that's what I'm saying. You need to have those good studies, and you have to do them usually once a year.

Q So with respect to the studies you reviewed of Mr. Snookal, what was the range that you observed in the records?

A 4.2. I keep talking about 4 and 4.2 because that's -- refers to this case. It is 4.2, pretty normal, mildly dilated by the number. And again, the 1 or 2 millimeters question mark, but needless to say, it's stable. So this 4.2 has been there, and I'm not going to say forever. What I'm going to look for all of the studies is I have seen is 4.2, which means it is not growing.

So the teaching is as long as there is no blood pressure -- what is a blood pressure? If you put a lot of water in this bottle, it might pop off. So the blood pressure is normal and you keep an eye on it, nothing has to be done. So it is a 4.2, and it is stable at 4.2. It is not going anywhere in the studies that I have reviewed.

Q So I guess, would you recommend surgery for Mr. Snookal at the size of the aorta that you observed

in the scans?

A You know by now, absolutely not. I would not recommend the 4.2, a 4.5. I would not recommend a 5. I would not recommend the 5.2. I would talk to the patient at 5.5 and say, "Here is the deal. This could rupture. 5.5, it is really big. Plus, the bigger it is, the more pressure it is, the more chances that also you could die during the surgery. So it is your decision how you want to deal with this."

My teaching point is that the 5.5, we offer surgery. I have to tell you at least half of my patients do not want to have surgery at 5.5. They usually get close to 6. Now, it is a bit more complicated if the valve -- that is the heart. That's the aorta. There is a valve in here. That is the aorta. And if this valve is not working, you have to go in and fix the valve, and then you repair the ascending aorta. And Mr. Snookal, the valve, it is pretty much okay.

Q Okay. What -- are there any other recommendations you would have with respect to Mr. Snookal at that time?

A 4.2 is considered pretty much close to normal. The risk of rupture, it's -- when we're not concerned with, say, less than one percent. It is usually

probably .1 to .2 percent. It is not significant, negligible. It is the same like in general population. Again, we look at the numbers, but we don't treat numbers. We treat patient.

So from a medical point of view, I doubt that the surgeon will actually even schedule him for a consultation because a 4.2 is not significant. It didn't grow. It is stable. All we recommend, and I agree with the other physicians probably going to come up, surveillance, this CT scan once a year to be sure it is not growing. Blood pressure, 120 not more than one 130, take your pills. Try not to bench 400 pounds because that is going to -- it is going to increase size in the blood pressure, pretty regular stuff.

Q In terms of preventive care, I think you mentioned an annual scan. Is that something that you would recommend to patients like Mr. Snookal with a 4.2 centimeter aorta?

A Yes, I would recommend to be safe once a year. You could make an argument that if it is not growing for a few years, you just don't want to give them contrast, you might want to do it every other year. You can do an electrocardiogram, take a transducer and put it on their chest. And it also gives you the size. It is a little bit more blurry. And now you know the 1 millimeter

makes a big difference. 4.1, 4.2 it depends on the X scales, the cursor. So echo, you get what you pay for. It is not the Cadillac of testing. Why? Because it is not that precise, but also, there is no down side. You just put the cursor on their chest, no contrast, no needles, no nothing.

Q Why recommend only a once annual screening and not more frequently than that?

A Well, because in plain terms, not a big problem. It is not a big deal. At 5.5, you'll do it once every six months. At 4.2, especially being stable for those all those years, no, I wouldn't do anything else.

Q You mentioned stability for all those years, what are you referring to?

A To prior testing that he had, CT scans and echo that showed that the aneurysm did not increase. And, again, I'm calling it an aneurysm, but it's -- aneurysm is usually over 4.5. We're talking about a few millimeters here and there.

Q Okay. In terms of any work restrictions for Mr. Snookal, would you have made any recommended restrictions as to what he could do for work?

A No, I would not in neither work nor travel. Again, it is pretty normal, 4.2. I mean, again, by

numbers it is a bit high by 1 or 2 millimeters. We don't treat numbers; we with treat patients. It could be that his size, that 4.2, is normal. No, he can travel anywhere he wants. He can go to Antarctica on a cruise ship, if he wants. Work-wise, he can do anything he wants. Again, common sense, don't go to the gym and try to bench 300 pounds. It is not going to help anyone, by the way. You could have an issue, herniated disk or anything. No, no restriction whatsoever.

Q You mentioned that an increase in blood pressure could increase a risk of rupture. Am I understanding that correctly?

A No, not really, not rupture. Increase the risk -- they don't rupture -- well, anything can happen. Only God can give them assurance, not me. It is not going to rupture, 4.2. But it will grow in theory the more blood pressure. We say no blood pressure, no grow. Sometimes when they are so small, I operate on them I just put a mesh. I don't replace them they are so small. But I do put a mesh. I wrap it with a mesh so it cannot grow anymore.

So, no, I don't -- I wouldn't even talk about rupture. It is so minimal the risk, probably .1 percent. With blood pressure from 4.2, it might get to 4.5, still nothing to be done. When I get to 5,

still nothing needs to be done. But you're not happy to see it growing because if it gets to 5.5, you need to operate, or 6. So you want to keep the blood pressure. There is enough margin there. But I'm not concerned of rupture. Well, especially in this patient. As far as I'm concerned, it is pretty similar to the patient population all around us.

Q Did you review any documents reflecting whether Mr. Snookal was taking any blood pressure medications?

A Yes, he was taking two blood pressure medication -- two pills, yeah.

Q And how did those interact to prevent any further growth of the aortic root?

A Well, there is good medication. I mean, they basically keep the blood pressure under control. No blood pressure, no increase in size, that is all we're saying.

Q Okay. I want to go back to something you said. So you corrected me about rupture. I'm sorry for misusing that. What is rupture just so you can explain to us?

A I don't want to spill this butter but, you know, a rupture would be something really bad. It rarely happens. It rarely, rarely -- except you talk about MVA trauma. There is an accident. There is the

seatbelt, holds the button here, upper part of the aorta moves forward in this area, kind of tears because one part is fixed, the other one is mobile. Gunshot wound. Stabs wounds.

Eventually, for an aorta to rupture at 4.2, at 4.5, at 5, I'm not going to say it is unheard, it is very, very, very minimal chance. They tend to have problems over 5.5. Nobody survives a major rupture. Ruptures could be in LA, could be in Africa, could be in New York. It doesn't matter. They almost never rupture in two. It just doesn't happen.

The ruptures that -- what you're talking about it is an intimal tear. So on the inside, they're three layers. The inside, there is a little bit of plaque, a little blood pressure. There is a small crack. The blood goes from the heart up to the body that keeps pumping. There is a little tear. That tear opens, opens, opens, and the blood sneaks underneath.

That's around 5.5. So because you have a lot of pressure, it's an aneurysm. 5.5, I can tell it's like this. And the aorta, by the way, is not like this. The aorta is probably this size. So that is the small -- that is the rupture we're talking about. So that creates a dissection and that dissection get them to the operating room. Okay.

So when we talk about rupture, we're not talking about tearing in half. We're talking about those small ruptures, tearing on the inside. Now, you can have a tear on the outside. It could be a big rupture in theory, or it could be what is called a pseudo false aneurysm. What it is, is a little tear that blood leaks out. But the aorta is in the body, so there are lots of things around it. So it becomes contained. So they come to the operating room -- well, they come to the emergency room first, and they have chest pain. Perhaps they have chest pain because, you know, they had some bad food the night before. We do a CT scan. And you see this little, tiny rupture in here, and you know it has been there for 20 years. It is chronic. It's got calcium. So the blood leaks out of the aorta, and there is a pool of blood here. It is called a pseudoaneurysm. So those are the different ruptures. You almost never have it in heart.

Q Okay. I think you said if someone suffers a rupture, most people don't survive. Is that -- so are you saying there is not medical intervention?

A No. I said I was only talking about the one that almost never happens. The rupture you see in trauma, in accidents, and so on. If it is a big rupture, they're dead within seconds. And that is not

the case here today because we talked about ruptures. At 4.2, it is almost normal. It is not going to rupture. The issue is that you could have a tear and anyone, by the way, not the 4.2. 5, 5.5, 6, 6.5 inside or outside -- what I said a major rupture will probably -- is unsurvivable anywhere.

However, a small tear, it is the same -- you might not need to operate on them, or you might operate on them, depends on where the tear is. Usually the ascending part, you operate all the time, the ascending part of the aorta. The aorta goes this way, and then you don't operate. You just watch it, or you put a stint in there certain ways.

Q I do want to ask you about the small tear, is that -- am I understanding correctly that that is what a dissection is, other sort of outcome?

A Correct. The dissection starts in an aneurysm. He doesn't have that. At 4.2, it is too small. That's 4.5, 5 5.5. An aneurysm is like a ballooning. And then a small tear in the inside gets blood in between the layers so the blood will sneak through here, will lift this wall up. And that is a dissection.

Q I do want to ask you is there any way to stabilize someone who has had a dissection?

A Of course. By now you know no blood pressure,

no rupture, no dissection. You drop the blood pressure immediately with pills or medication. So if we see a dissection on the films, the first thing we do, we give them a medication that slows down the heart rate to 50. It is called decreased DPDT.

So what you do is you decrease the heart rate because, boom, boom. All those things, they enlarge the dissection, and they increase the possibility of a rupture or more of a complication. So from 90 you decrease the heart rate to 50. What it is going to do is decrease the blood pressure probably around 100 and you want 80 to 90.

And then if that doesn't do it, all those that go -- drips, IV immediate -- instant gratification. You look on the monitor how the blood pressure and the heart rate drops. Then you give more medication and you drop the blood pressure. And if they have a dissection, they -- never that stable but they are better off -- more stable in terms of getting them to the operating room.

So to answer your question, we give them medication to get them to the operating room.

Q And in your experience as a surgeon here in Los Angeles, have you ever seen patients get delays in actually going to the operating room once they've had a

dissection?

A Almost all the time. That's the rule. Nobody dissects. Only certain hospitals in Los Angeles can do this kind of procedure. Got to open the chest. A lot of times you put them on what -- always you put them on a heart/lung machine. But a lot of times we have to cool them down to 15 to 20 degrees Celsius, put their head down this way, pack it in ice, and take all the blood out and stop the machine.

Again, there is no heart/lung machine. Patient is cold, so we can actually cut the aorta. There is the aorta and you replace. You put a tube in here, and then we turn on the machine back, put the blood back in the patient, warm him up. And then, you know, you're hoping they don't have a stroke or anything. But that is the way to do it.

Only some hospitals do this so if it happens in any hospital, it is more hospital downtown or Arcadia or God knows -- Palm Springs, they will need to make it to a big hospital. And unfortunately, almost all the -- the insurance is an issue. The transfer is an issue in terms of no beds and the availability. So there is almost always -- more likely than not, there is a delay somewhere for those patients to make it from hospital A to a universal large hospital who can accommodate this

surgery.

Q So when someone dissected and had to deal with the delays that you described, how long have you witnessed it to take for someone to get surgery after that happens?

A In between eight hours and four days, anywhere there.

Q Okay. I want to turn to your report directly. The exhibit you have in front of you. If you can kindly turn to Exhibit 7. I'm sorry. Oh, my gosh, the same exhibit we're looking at, page 7, excuse me. So on that page, you write, quote, "In my expert opinion and according to the clinical data, ascending aortic aneurysms between 4 and 4.9 --

MR. MUSSIG: Objection, Your Honor.

THE COURT: There is no question yet. She is just in the middle of it. Go ahead, Counsel.

MS. FLECHSIG: Thank you, Your Honor.

BY MS. FLECHSIG:

Q "Between 4 and 4.9 centimeters carry a very low annul risk of rupture or dissection estimated at roughly one percent per year in this size range. This risk is considered negligible compared to the general population, especially given the absence of rapid growth in Mr. Snookal's case."

just allow you to speculate on everything. I think the question was just -- let me look at it again -- whether since 2019 to the present, has the understanding of the medical community changed as to the issues that you've discussed?

THE WITNESS: No.

BY MS. FLECHSIG:

Q Okay. In other words, the general research about what to do when someone has a dilated aortic root and the risk associated with it, it is basically the same now as it was then?

A Correct.

Q Okay. When you formulated the opinions that you put into your report, did you consider the fact that Escravos, Nigeria, where this job was located, is extremely remote and has limited surgical capability nearby?

A Yes, I did. My opinion is based on medical data and not on geography. So his risk, his condition remains the same regardless where he is located, New York, Los Angeles, or Escravos. His location has nothing to do with his risk of disease.

Q Right. So if Mr. Snookal was your patient, you would clear him wherever in terms of work?

A Correct. Wherever, yes.

Q Okay. Is there anything about Escravos, Nigeria or any other location that would make Mr. Snookal more likely to eventually have a rupture or a dissection?

A No, nothing.

MR. MUSSIG: Lacks foundation, Your Honor.

THE COURT: Overruled.

BY MS. FLECHSIG:

Q Is there anything about -- excuse me -- I will establish the foundation for this. I believe you reviewed the job position in question; correct?

A Yes, I did.

Q Was there anything about the intended job duties in Escravos that would pose a threat to Mr. Snookal's safety or worsen his condition?

A No.

Q Are you aware of any medical guidelines that would instruct a healthcare provider or doctor to stop someone, like Mr. Snookal, from traveling to remote locations?

A There are no -- there are -- I'm not familiar, but -- well, I am familiar, but there are no guidelines that would stop a patient, like Mr. Snookal, to travel or to work in that location.

Q Okay. And if Mr. Snookal were your own patient

and you were personally responsible for ensuring his care as his physician, you would make all of these same recommendations?

A Absolutely. He can travel anywhere he wants in world for any period he wants. I would reemphasize that I would like him to be tested once a year with a CT scan and to take his medication and, again, try not to bench 2-, 300 pounds.

Q Okay. I want to very quickly turn to -- excuse me. I want to ask you about a supplement you did to your initial expert report.

Do you remember creating this document?

A Yes.

Q Okay. What did you express as to Mr. Snookal's annual risks of rupture or dissection?

A Less than 1 percent, negligible.

MS. FLECHSIG: Okay. I have no further -- or, excuse me, I would move to admit Exhibit 122 into evidence.

MR. MUSSIG: Objection; it's hearsay.

THE COURT: Overruled. 122 is admitted.

(Whereupon, Plaintiff's Exhibit 122 is admitted hereto.)

THE COURT: All right. I think this is a good time for a break. So let's -- let me remind our jurors my admonition not to talk amongst yourselves about the

BY MR. MUSSIG:

Q Sure. So your knowledge of Escravos is based on Google Maps?

A Correct.

Q But you've never been to Escravos; right?

A You already asked me. No, I've not been there, no.

Q And so do you know what the weather is like in Escravos?

A Today, I can check, no. It's probably warm, Africa.

Q Do you know what the climate is like, generally?

A Climate? If it is gets cold at night or warm during the day? I'm not sure I understand the question.

Q Do you know whether there are monsoons in the winter?

A Actually, no, I didn't look into this.

Q Okay.

A I mean, it's close to -- to the equator so could be.

Q And do you know how hot it gets in the summer?

A Actually, I don't, no. I would assume it's hot, but I don't know.

Q But even though you've never been there, you --

you would have cleared Mr. Snookal to work in Escravos?
A Yeah.
Q Yes or no?
A He's -- from a medical point of view, has absolutely nothing to do with having or not having monsoons or it being hot or cold, yeah, no. From a medical point of view, he's clear, correct.
Q Doctor, my -- it's a yes-or-no question. If you would just please answer the questions, this would go a little quicker.
And in your deposition, you testified that you would have cleared him to work anywhere; correct?
A Exactly.
Q You would have cleared him to work in Antarctica?
A Yes.
Q You would have cleared him to work in an oil rig in the middle of the Pacific a thousand miles from anywhere; is that correct?
A That's correct, sir.
Q And how much money are you getting paid to be here today to testify?
A I'm being paid for my time, correct, yeah.
Q How much?
A $10,000.

Q Fair enough. And so you would have cleared Mr. Snookal to work in Escravos, and it doesn't matter to you what the living conditions there are; is that fair?

A Fair, if he would live in a tent or in an igloo, wouldn't matter. From a medical point of view, I cleared him to work. Size (indiscernible). The 4.2 size, that did not change. Doesn't make a difference if he has a monsoon, a river, a tent or he lives on the moon; same.

Q So you would have cleared him to work on the moon?

A I would have cleared from a medical point of view. And I said earlier and I just -- perhaps I didn't clear it. I think there's a misunderstanding. I'm talking about medicine; you're talking about logistics for your company. From a medical point of view, there is no problem with him. From a Chevron point of view, there is a logistics issue based on their guidelines, based on their rules, regul- -- whatever it is.

THE COURT: All right. Doctor, look, I'm going to stop you from testifying about what you believe Chevron's policies or logistics are. But I think you've made your point. Next question.

MR. MUSSIG: Thank you.

aneurysm starts around 4.5. A 4.0 is normal. So from 4 to 4.5, if you want to call it an aneurysm, it's okay.

Q So, Doctor, please answer my question: Are you saying that if his cardiologist says he does have an aortic aneurysm, his cardiologist is wrong?

A I never said that. It's his opinion.

Q But you said he doesn't have an aneurysm?

A From my point of view, a 4.2, you don't really have to call this an aneurysm. That's my answer.

Q Have you ever talked to Mr. Snookal about his condition?

A Yes.

Q When?

A I don't remember. Probably, like, a month ago.

Q A month ago?

A Might be a few weeks ago. More than two weeks, less than a month, I think.

Q And that was the first time you had ever talked to him; right?

A That's correct.

Q And that was after you gave your expert report in this case that you talked about on direct examination; correct?

A That's correct.

Q Have you ever treated Mr. Snookal?

A Yes, but it's not because I think he needs care. I'm saying he doesn't need care.

Q Okay. But the reason he wasn't cleared, from your point of view, is a logistical issue?

A It's not my point of view. It's based on the records I reviewed.

Q Okay. Fair enough.

A Yes.

MR. MUSSIG: No more questions.

THE WITNESS: Okay.

THE COURT: Wait just a second, Doctor.

Any redirect?

MS. FLECHSIG: Yes, please.

THE COURT: Okay.

REDIRECT EXAMINATION

BY MS. FLECHSIG:

Q Okay. Doctor, you testified that you reviewed depositions that were taken in this case. Did any of those depositions describe the remote conditions in Escravos?

A Yes, to some degree.

Q Did they describe the degree of care available or not available in Escravos?

A Yes.

Q And you considered -- did you consider that

before rendering this opinion?

A Yes.

Q They referenced you speaking with Mr. Snookal. Did speaking with Mr. Snookal change any of your opinions or evaluation of his management and risks associated with the dilated aortic root?

A No, it did not change.

Q Defense counsel asked whether you've ever practiced medicine in Nigeria. I know earlier you mentioned that you do travel abroad to do charity surgery cases. How familiar are you with caring for patients in medical systems with limited care or less resources for care?

A I'm quite familiar. I mean, I've been to Africa and certain locations, not to Nigeria. I ran several mountain rescue terms, sea rescue teams. I'm familiar with logistics in terms of rescue operations. I mean, his risk is the same, like pretty much everybody around, negligible, in my opinion, less than 1 percent. I would not stop him from going anywhere.

Q I just wanted to quickly look at the exhibit that -- I think it's Exhibit 68. It's marked as CUSA 557. It's that letter that -- from Dr. Khan that Mr. Mussig showed you a moment ago.

Dr. Levy also says in this document, "In

THE COURT: You can help us by speaking closely into the microphone. And do your best to wait until the question is finish and then pause in case there's an objection.

THE WITNESS: I will.

THE COURT: All right. If you can, state your full name and spell your last name.

THE WITNESS: Full name is Shahid Khan, K-H-A-N.

THE COURT: Very good. Thank you.

Go ahead, Counsel. Oh, you have a -- when you refer to them, make sure to reference the exhibit number in the broader set, as well.

MS. FLECHSIG: Okay. Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. FLECHSIG:

Q Dr. Khan, thank you so much for taking your time to be here today.

Can you tell us what is your profession?

A I'm a physician and a cardiologist, to be specific.

Q Okay. What training did you undergo to become a cardiologist?

A Well, I went to college, medical school, residency, fellowship.

Q Do you currently practice medicine as a cardiologist?
A No. I'm retired now -- fully retired.
Q Do you have any subspecialization in the field of cardiology?
A I did a lot of research on heart valves and then heart failure, and those are the main areas -- and women in heart disease -- heart disease in women.
Q Do you have any board certifications?
A Yeah, I'm board-certified in internal medicine and in cardiology.
Q Okay. Can I ask you why you wanted to become a cardiologist?
A I was trained as an engineer undergrad, so I wanted to apply that, and cardiology was a good field to do that.
Q Are you familiar with a medical condition called a dilated aortic root?
A Yes.
Q Okay. Do you sometimes also refer to it as an aortic aneurysm?
A They're two different entities, actually.
Q Okay. What's the -- what's the difference, in -- in your opinion?
A Well, there's definitions, so it is not my

opinion. But there's definition from the European Society of Cardiology, American College of Cardiology, and so on.

Q Okay.

A So it depends on the size.

Q Understood. Thank you for clarifying that. Do you have just a best estimate of how many patients you've treated over years who have a dilated aortic root?

A I do not.

Q Can you -- can you give me your best estimate? Is it less than a hundred, less than 200?

A You know, it's very hard to say because I worked in a cardiac surgery intensive care unit at Cedars for, you know, 15, 20 years. So we saw lots of patients with dilated aortas, and so it is very hard for me to make an estimate. But it would be more than a hundred, probably.

Q In 2019, do you remember where you were working at the time?

A Yeah, I was at Kaiser Permanente Los Angeles.

Q Were you Mr. Snookal's treating cardiologist in 2019?

A Yes.

Q Okay. Do you remember when you started

treating Mr. Snookal?

A I don't.

Q Was it before 2019?

A Not sure.

Q Okay. I want to ask you just some very background questions.

Were you hired as an expert for either Chevron or for Mr. Snookal in this case?

A No.

Q Are you being paid for your testimony today?

A I'm hoping to get parking re-embursement, but that's it.

Q I have told you -- I have told you we will reimburse your parking. I'm so sorry. We appreciate your time.

Do you have any agenda against Chevron?

A No.

Q Okay.

A My son works for Chevron, and he is an attorney there. He is lead counsel -- or he was promoted. Now he is -- and I own Chevron stock too. So...

Q Okay. So I know it's been a while. So -- and it is not a memory test. So I do want to go to what's been marked as Exhibit 13. You have that in your binder in front of you?

apologize. Let's go -- I want to be respectful of your time.

So let's go to Exhibit 15, if you would, please.

A Uh-huh. How does that start? So I can make sure --

Q It looks -- I believe in the bottom right page, go to page, I think, 6. Bottom right should say page 16, and then the next page says page 425.

A My first page here says 49, then 50, then 51. And it drops back --

THE COURT: Yes. Let's refer to that joint set because I think your --

MS. FLECHSIG: I'm sorry, Your Honor.

THE COURT: -- your witness binder is much different. So let's just get rid of that.

MS. FLECHSIG: Okay. I apologize.

BY MS. FLECHSIG:

Q Exhibit 13, does that say "818"?

A Exhibit 13, 006.

Q Perfect. Thank you so much. Thank you so much, Doctor.

Have you seen -- can you describe the document in front of you?

A So what I'm looking at is a -- again, result

notes for CTA cardiac with contrast and notes I made on April 11, 2019. So basically, I had reviewed the CT scan results and it says, "Center nurses, please let patient know his aorta looks stable on his recent CT, no change in aortic size." And then it gives the results of the CT angiogram, which is the aortic root is stable at 4.2 centimeters, maximal --

THE COURT: Show down, Doctor.

THE WITNESS: Oops. Sorry.

Aortic root is stable at 4.2 centimeters. Maximal size of ascending thoracic aorta is 4.1 centimeters. Compared to 5/16/17, there has been no significant change.

BY MS. FLECHSIG:

Q So, Doctor, I want to ask you about that. You said there was no significant change.

Why does it matter that the size of the aorta has been stable over time?

A Because that's one of criteria that we can use for deciding whether we need to follow the patient a little more closely and if the patient is risk for any problems.

Q So if they're stable, then you follow the patient less closely?

A Um, we would continue to follow with the same

frequency. We wouldn't need to speed up follow-up.

Q Okay. What would be your recommendation in terms of screening Mr. Snookal for changes in size to his aorta?

A At this level and, you know, given the fact that he has no associated conditions, it would be about once a year.

Q Okay. And why do you recommend an annual screening and not something more frequent or less frequent than that?

A The newer guidelines are actually less frequent for somebody with his condition. It would be every two to three years instead of every one year -- the current guidelines. The guidelines at the time were once a year follow-up.

Q I guess is something that you're monitoring for? Is there something where it reaches a point where you need to intervene medically?

A Right. If it reaches a certain size, then we would be concerned that he might need surgery. Then we would refer him for a surgical evaluation.

Q At 4.1 or 4.2, would you recommend a surgery evaluation?

A Not for Mr. Snookal, no.

MS. FLECHSIG: I offer Exhibit 13 into

with my condition and that, quote, "Everything is under control, and no special treatments are needed," end quote. Is this something you can provide? Thanks, Mark."

You agreed to provide the letter based on Mr. Snookal's request; right?

A Yes.

Q Is that something you would have done if you thought that it would endanger Mr. Snookal?

A No.

Q Why did you not think that working in Nigeria was a danger to Mr. Snookal?

A Because the interval of follow-up for this condition is quite long. As I said at the time, we were doing CTs once a year. I think now we realize it is safer, so we backed off to every 2 to 3 years under the 2024 guidelines. He does not have any high risk characteristics that would make us concerned. So it is just a routine once a year return visit for checking up on his aortic size.

Q Okay. Is that true even if the job in Nigeria was located somewhere really remote? Would that change your clearance?

A Based on his aortic size at that time and his other conditions, no.

before providing this clearance, did you also consider whether Mr. Snookal was managing his condition with any medications?

A Yes.

Q What kind of medications would manage this condition?

A Well, the main issue is blood pressure control, so he was on blood pressure medicines at that time.

Q Okay. And how does it control -- how do blood pressure medicines serve to manage dilated aortic root?

A Well, the blood pressure is one of the forces that makes the aortic expand. So if the blood pressure is out of the control, it would not be a good thing.

MS. FLECHSIG: Okay. Moving onto Exhibit 68. This also -- the admissibility has been stipulated to. May it be published to the jury?

THE COURT: Go ahead.

(Whereupon, Plaintiff's Exhibit 68 is admitted hereto.)

BY MS. FLECHSIG:

Q Dr. Khan, you probably see in front of you a lengthier e-mail. It looks like you said on August 23, of 2019, addressed to a Dr. Levy, is that -- are you seeing where I'm looking at?

A Uh-huh, yes.

Q So you said, "I understand he is applying for a

job in rural or remote Nigeria, and I understand the concern for his aortic aneurysm." So based on that, I mean, do you remember if you had a sense of how remote the location was?

A Again, I don't think I looked up the location at that time.

Q But you knew enough to document that it was in a rural or remote area of Nigeria; correct?

A Correct. I was told that, yep.

Q All right. Going down the document, at the bottom there, the last big paragraph, you said, "In summary, Mr. MS's risk of serious complications related to his thoracic aortic aneurysm is low and likely less than 2 percent per year. The risk is primarily related to further enlargement of the aneurysm, which can be tracked with an annual CT scan, end quote."

So I guess -- am I understanding correctly that the purpose of the annual scans is to make sure that there hasn't been growth?

A Yeah, that's the -- that is the primary purpose, yes.

Q Okay. If there -- if there has been growth in the intervening time -- so, you know, the year goes by and he hasn't had his scan just yet, is there any way to track a large change?

A I don't understand the question.

Q Sorry, I did not ask a good question. I guess time passes for a year, and during that year, Mr. Snookal is not getting a scan; right? So I guess why are you not worried about a sudden large change in the size to the aortic aneurysm?

A Well, it just doesn't happen. I mean, they typically grow fairly slowly. If there is going to be any kind of progression, the typical rate of growth would be -- the literature at the time said .1 centimeter per year. So he looked like he was at least 3 to 8 years away from needing anything done at that point.

Q Okay. Thank you so much, Doctor. I think those are all of my questions.

THE COURT: All right. Cross-examination?

CROSS-EXAMINATION

THE COURT: Go ahead, Counsel.

BY MR. MUSSIG:

Q Good afternoon, Doctor.

MR. MUSSIG: Could we pull up that same exhibit, Exhibit 68?

BY MR. MUSSIG:

Q And we were looking at this a moment ago, Doctor. This is the e-mail you sent to Dr. Levy;

aneurysm in medical terms, but we're in layman's terms. We're calling it an aneurysm. Let's put it that way. This is more layman's terms, but it is not technically correct. It is not an aneurysm at that point.

Q Understood. And so you say the size is 4.1 to 4.2 centimeters on his most recent CT scan. And that 4.1, 4.2, you're confident in that number?

A He's had, I think, three CTs at that point, and they all showed the same numbers so that certainly makes the confidence quite high.

Q All right. And then you say from the published studies, the risk of rupture or dissection is 2 percent per year. And I think you cite -- well, let me ask: What publication are you citing?

A Yeah, there is a paper I think it was in *The Annals of Thoracic Surgery* -- I don't know if I have the reference -- oh, yeah, it is here, *Annals of Thoracic Surgery*, 2002. But I state the studies are pretty old. Treatment is improved as has our understanding of aortic aneurysms.

Q Understood. Is that a publication that you would cite frequently in your practice?

A I publish a bunch of papers, and then I do cite it, you know, when I worked at Cedars, yeah, quite a bit.

Q Okay. Is it a reputable publication?
A Say that again.
Q Is it a reputable publication?
A Yes, it is an official organized society of thoracic surgeons. So, yeah, it's very reputable.
Q Understood. And I have a question about what that 2 percent per year means. Does that mean that out of a hundred people, two per year would rupture or dissect with aneurysms of this size?
A It does, which that number has been modified significantly because this is a very unselected group in that -- in that publication.
Q When you say "the number has been modified significantly," do you mean in recent years?
A Yeah.
Q Understood. So back in 2019, this is what the understanding was; right?
A Yeah, I would say it's a reasonable estimate, yeah.
Q And then later in your e-mail, you do say -- and you saw this language a few minutes ago -- that because the aneurysm was stable, it -- it could be -- might be less than 2 percent per year?
A Yes.
Q Do you recall seeing that?

A Right.
Q But did you ever clarify for Dr. Levy or anyone else how much less?
A No. Again, at that point, I think our understanding of these was not as good as it is now. But that was just basically people at work with patients with a certain condition tend to have a deeper understanding of what is going on than what is in the literature. The literature tends to lag behind.
Q Okay. But you have that deeper understanding; right?
A I mean, probably more than most cardiologists.
Q I have no reason to doubt that.
So -- so but -- so you're focused in this email to Dr. Levy of 2 percent per year; right?
A Yeah, I mean, I basically -- you'd like to cite a source. I mean, that is what we do when we write scientifically in an article or, you know, book chapter or something like that. We cite a reference so that was a reference I pulled up. It was probably one of the first ones I found.
Q Let me ask you a slightly different question?
A Uh-huh.
Q So based on your experience and training, if an aortic aneurysm ruptures, what happens? What does a

patient need?

A Well, these types of dilated aortas -- aortic aneurysms don't typically rupture per se. They tend to dissect, what is called an aortic dissection. Or they can have other complications such as a perforating ulcer or integral hematoma. So it would be exceptionally rare for this to rupture, especially given that he is what we call a non-syndromic aortic dilation.

Q So more likely to dissect?

A It would be more likely to present as dissection or one of those other acute aortic syndromes, we call them.

Q Understood. And in the event of dissection, what -- what does the patient need?

A If the starts to dissect, he'll typically have symptoms, and then they -- we would need to get them to a hospital.

Q They need to have surgery done?

A They need to have a CT scan done first, yeah.

Q Okay.

A Or a transesophageal echo, we do sometimes.

Q I'm sorry, a --

A Or a transesophageal echo.

Q And how soon after the dissection would that happen, from your perspective?

A It depends on where they are. So this is a frequent reason people get transported to the hospital. So at Cedars, we would get a lot of helicopter transports in from central California, or wherever, to get CT or transesophageal echo and make a diagnosis and then triage them, whether they needed surgery urgently or if they could wait.

Q Okay. Isn't it fair to say that you want this dissection treated as soon as possible?

A I think we need a diagnosis first. So we need a diagnosis as soon as possible, and then the treatment will be based on what the specific diagnosis is.

MR. MUSSIG: Your Honor, I'd like to read from his deposition.

THE COURT: All right. Just a second. Let me get the --

MR. MUSSIG: If we have a copy. If we don't, I'll move on.

THE COURT: No?

Then you'll need to move on.

BY MR. MUSSIG:

Q In the event of a dissection, how soon should the person have this -- the word you referred to a minute ago, the examination and then -- and then surgery?

A Again, it depends on the location of the dissection. So it depends on whether the dissection is in the ascending aorta or descending aorta. Descending aorta, we can manage conservatively. We don't have to take them to surgery, again, depending on the specifics. Ascending aortic dissection, we would need to take them more urgently.

Q And was Mr. Snookal's aorta in the ascending area?

A Yeah.

Q And sorry, his aneurysm in the ascending aorta?

A His aortic root was dilated in the ascending aorta, yeah. That doesn't mean that's where the dissection would occur, but it was dilated in the ascending aorta.

Q Wouldn't it be most likely to occur there if it was going to occur?

A Not necessarily, no.

Q Why not?

A Because, typically, it can happen anywhere in the aorta, basically.

Q All right. Let me ask a different question: Do you -- do you -- and let's -- by way back, you've never been to Escravos; correct?

A To where?

Q Escravos?
A In Nigeria?
Q Escravos, Nigeria?
A No.
Q And so I take it you don't know anything about the job Mr. Snookal would have been doing in Escravos?
A My impression was -- I think I put it in my deposition, that it was something managerial. But I do remember writing -- or I saw that I wrote in there, also, that he had told me that he was climbing ladders.
So my father worked at an oil refinery. He was a chemical engineer. So I know that it can be pretty physical to climb ladders and stuff like that and inspect things and try and figure out why something is blocked or not.
Q It can be a physically demanding job; right?
A It can be, yeah.
Q And do you know whether Mr. Snookal would be working eight-hour shifts? Twelve-hour shifts? Twenty-four-hour shifts?
A I don't think I got any of that level of detail.
Q And do you know anything about the weather in Escravos?
A No.

Q Is it fair to say that a person working, say, 12-hour shifts, a physically demanding job, in places where the temperature gets up to 115 degrees in the summer and there are monsoons in the winter, could suffer stress as a result of all that?

MS. FLECHSIG: Objection; incomplete hypothetical.

THE COURT: Overruled.

THE WITNESS: Well, yeah, I mean, your question is sort of self-evident, I guess.

BY MR. MUSSIG:

Q And those conditions could drive up someone's blood pressure, right?

A I don't think high temperatures necessarily would, but certainly climbing a ladder. Yeah, if he's going up a ladder, that could -- or would.

Q And isn't it true that something -- if something were to drive up his blood pressure, it could potentially exacerbate this aortic aneurysm?

A It is a chronic process, yes. But again, I mean, these are true for everybody with this condition.

Q Sure.

A Their blood pressure is going to go up and down depending on who cuts them off in a parking space or, you know, whatever.

REDIRECT EXAMINATION

BY MS. FLECHSIG:

Q Dr. Khan, do you have any memory of anyone at Chevron trying to speak with you in realtime about Mr. Snookal, other than the voicemail you received?

A I don't have any other -- any memory of that.

Q Okay. If they had contacted you again or needed more information, would you have cooperated with that?

A Yes.

Q If Mr. Snookal was doing an office job in a remote location, such as Escravos, Nigeria, would that change any of the clearance letters you provided?

A No.

MS. FLECHSIG: No further questions. Thank you.

THE COURT: May he be excused?

All right, Doctor, thank you for coming today. You're excused. Have a good day.

MS. FLECHSIG: Thank you, Doctor.

THE COURT: All right. Who does Mr. Snookal call next?

MS. LEAL: Dr. Levy.

THE COURT: Okay. Let's get Dr. Levy in here.

MS. LEAL: May I approach, Your Honor, to put

manage people who get sick and hurt. Make sure we have programs to keep people healthy.

Q Okay. And you did that for how long?

A I did that -- I was in that position for about two years, and then I was moved to Singapore to take a larger role managing occupational health -- really, all of health for -- for the Asia Pacific region, so everything from China down to Australia and as far west as India.

Q So it was the same job, just a larger geographical responsibility?

A Correct. More responsibility, more people, yes.

Q Okay. And during that period of time, how many -- how many persons reported to you?

A We had a total -- we had approximately 300 medical providers that reported up to us -- that reported up to me. Some reported directly; some were contractors. But it was a relatively large group.

Q And these 300 medical providers were in the Asia Pacific region at the time?

A Correct.

Q Okay. And how long were you in that position?

A Three years.

Q So then --

A Three years.

THE COURT: Just lean -- bring the microphone a little closer.

BY MS. LEAL:

Q So then we're talking about approximately 2017/2018?

A Correct.

Q And after that role in Singapore, what was your next role at Chevron, Doctor?

A I was moved to London to manage a similar type of role across a different region. We called it EEMEA, Europe, Eurasia, the Middle East, and Africa.

Q A very large role. EE- --

A -MEA.

Q -- -MEA. EEMEA. Okay.

So your responsible for Europe, Eurasia, Mid East, and Africa?

A Correct.

Q And you were working in London, did you say?

A Yes.

Q Okay. And how long were you in that position?

A In total, seven years.

Q So you were in that position, the EEMEA regional medical manager position, during the events at issue in this case in 2019; correct?

A Correct.
Q Now, you've been in a number of different roles with Chevron, including transferring from Houston to London to Asia, Singapore.
Every time you transferred, Chevron still continued to be your employer; correct?
A That's correct.
Q And you continued to be on the same Chevron payroll; correct?
A That is correct.
Q And the same Chevron benefits; correct?
A Yes.
Q Okay. So now, the rest of my questions now are going to be focused during the time that you were the EEMEA regional medical manager. Okay? Again, in 2019.
A Okay.
Q Now, in your role as the EEMEA, were you -- regional medical manager, were you aware of the process of what happened when an employee in the States, for example, wanted to transfer to another country, be an expat employee?
A I am -- I was very aware.
Q Okay. And as part of that process, a doctor in the United States, where the employee lived or work, was required to be medically examined; correct?

A That is correct. We would call these evaluations MSEA evaluations, or Medical Suitability for Expatriate Assignment evaluations.

Q And the doctors who performed those evaluations for Chevron, those doctors were paid by whom?

A So those doctors were paid in a variety of different ways. If they're -- if the person was seen in one of our own medical clinics, then it would have been Chevron that pays for it.

Q Did the employee who was being evaluated or going through the fitness for duty exam --

A The company would pay for it all. It was not something that would be covered by insurance. So there's no cost to the employee. The total cost is to the company.

Q So Chevron would have paid?

A Yes. Sorry for misspeaking.

Q So why don't I now show you Exhibit 29, which is the MSEA, which you just referred to.

THE COURT: This has been admitted by stipulation?

MS. LEAL: Yes, Your Honor. Thank you.

THE COURT: Go ahead.

(Whereupon, Plaintiff's Exhibit 29 is admitted hereto.)

THE COURT: Is it in front of him?

also admitted by stipulation, Your Honor?

THE COURT: Okay. Go ahead.

(Whereupon, Plaintiff's Exhibit 33 is admitted hereto.)

BY MS. LEAL:

Q Is Exhibit 33 before you Dr. Levy?

A Yes, it is.

Q And again, you've seen this letter before?

A I have.

Q And this is the letter that Dr. Khan wrote to Mr. Snookal in order to submit to Chevron in essence saying that he believes -- he, Dr. Khan, believes that it's safe for Mr. Snookal to work in Nigeria with his heart condition?

A That's correct.

Q Okay. And he also says his condition is under good control and no special treatments are needed.

Were you aware also that Dr. -- strike that.

Were you aware that Mr. Snookal also submitted, as part of his package, the CT scans which Dr. Khan had performed over the years?

A I'm aware of the CT scan reports that were sent over, correct. And I reviewed those reports.

Q Thank you.

So after the fitness for duty exam was completed and the doctor deemed Mr. Snookal fit for duty

with the restrictions -- Dr. Sobel I'm referring to -- the next step was for the medical team in Nigeria to then review the medical records of Mr. Snookal; correct?

A Correct.

Q Okay. And those medical teams, I think you called them embedded medical teams?

A I -- I did. And what that means is that they report -- or they're hired by the business. So they're hired by the Nigerian business. They work for the business, and they're sitting where the work is.

Q Okay. And so the embedded medical team in Nigeria, at least in 2019, included Dr. Asekomeh?

A That's correct.

Q And Dr. Adeyeye?

A Yes.

Q And Dr. Akintunde?

A Correct.

Q I may not be pronouncing the names correctly. But you know who I'm referring to; correct?

A Correct.

Q When you were the regional medical director of the EEMEA -- that is a very large acronym here -- you were the leader, then, of large diverse embedded on-site medical teams; correct?

A That is correct.

Q Approximately how many medical providers were you responsible for supervising during that time?

A It was somewhere between 3- and 400. Our Nigeria team had about 200 people on it, and I also had large teams at other locations. Angola was another large team. Kazakhstan was a large team but not as big as Nigeria.

Q So during the time that you were the medical director of the EEMEA, you actually supervised at least 500 medical providers; is that correct?

A It was a lot. So yes, it is -- the number is probably very close.

Q And during the time that you were the regional medical manager for the EEMEA, what was your overall budget?

A So my budget that I was responsible for was just my local team in London. So the budget was approximately three million USD a year.

Q Did you put on your CV that your budget exceeded $40 million?

A It has in lots of different ways. So my -- my budget that I was responsible for was three million of my own team. I was then functionally responsible for -- I was the leader of the health function, and so the Nigeria budget was about 20 million. Angola budget was

A I do.
Q You've seen this document before today; correct?
A That is correct.
Q And this document is the document signed by Dr. Asekomeh where he specifically said --
MS. LEAL: And if you can highlight that Ms. Stephens?
BY MS. LEAL:
Q "Not fit for duty. Remote location. Can be cleared for assignment in Lagos" -- or "Lagos."
A Correct.
Q I don't know how to actually correctly pronounce it.
And as the regional medical manager for EEMEA, you were sometimes involved in reviewing determinations such as the one made by Dr. Asekomeh whether or not a person is fit for duty; correct?
A That is correct.
Q And as the EEMEA regional medical manager, under what circumstances did you get involved in situations where fitness for duty was an issue?
A So we got involved in a few different ways. So if my team -- so in my region, did the evaluation. I'd be aware of the process and what was going on and who

Levy --

A Yep.

Q -- to Mark Snookal. Subject, medical. And then you say, "Mark, thanks for speaking with me, et cetera." Do you recall sending this e-mail to Mr. Snookal?

A I do. I do. So I obviously spoke with him.

Q Okay. And if you turn to the first page of Exhibit 65. There is an e-mail also underneath the black box from Mark Snookal to you, the same day. And he is responding to your e-mail and providing you information. Do you remember having received this information from Mr. Snookal?

A Yes, I do.

Q And you recall there is a graph on the second page. Do you recall seeing that graph?

A Yes, I do.

Q And what did that graph tell you when you saw it?

A It told me what Mr. Snookal's opinion of his risk was and what he based it on.

Q And what was that?

A According to this chart, the risk appears to be less than one percent.

Q So when you were evaluating Mr. Snookal's case

for a second opinion, if you will, you were also evaluating the risk for -- the risk of an adverse event occurring to Mr. Snookal in Escravos; is that correct?

A That is correct. We were looking. We --

Q Thank you.

A Yes.

Q Did you consider the actual diameter of Mr. Snookal's aortic aneurysm?

A Yes.

Q And you also, I assume, considered the fact that Mr. Snookal had not had any changes in size of his aortic root over the prior three years?

A Yes.

Q We can put that exhibit down.

And at the time you were reviewing Mr. Snookal's case for a second opinion, did you evaluate whether Mr. Snookal's management with medication impacted the risk of an adverse outcome due to the aortic aneurysm?

A Yes, that would have been part of the evaluation. After -- I don't think there was any medication-related issues that we saw as a problem.

Q And you took that as Mr. Snookal being relatively stable; correct?

A Yes.

A I have.
Q And is this document an e-mail which Dr. Khan sent you in response to the voicemail message you left him requesting additional information with respect to Mr. Snookal?
A Yes, it is.
Q Okay. And isn't it true that you learned that Dr. Khan acknowledged that he knew Mr. Snookal was applying for a job in a rural or remote area of Nigeria?
A Correct.
Q And it's also true that you learned that Dr. Khan was reporting to you that he believed that Mr. Snookal's aneurysm was relatively small and considered low risk?
A He did; however, the low risk piece is not clear to me.
Q Did you call him if it wasn't clear to you?
A The word low risk --
Q Did you call Dr. Khan if it was not clear to you? Did you call him to say, "Well, what do you mean by low risk?"
A I did not call as the risk was 2 percent so it was -- calling it low and calling it 2 percent are two separate things. I understood what he was saying.
Q Oh, so you did understand what he was saying.

that says his risk is low and less -- and likely less than 2 percent based on the information. So 2 percent is not low to me. And that's possible.

Q What's possible?

A If there's -- risk is 2 percent a year, then it's possible to rupture at that size.

Q And you base that on what --

A What it says, according to his specialist.

Q He says that there's a 2 percent chance of rupturing?

A "Serious complications," yes, that's what it says.

Q Does it say "rupturing"?

A It says "serious complications."

Q It doesn't say "rupture"; correct?

A There are only two significant consequences: dissection or rupture.

Q Correct. You didn't call Dr. Khan to find out what he meant by "serious consequences" to find out whether there was a rupture or -- or a dissection; correct?

A I didn't, but the --

Q Okay. Thank you.

A It's understood.

Q Thank you. Thank you, Dr. Levy.

Isn't it true that the job which Mark Snookal sought in Escravos, Nigeria, was an office-based job where he would be supervising other employees; isn't that correct?

A Yes, it is.

Q And isn't it true, Dr. Levy, that you agree that Mr. Snookal's condition or the dilated aortic root did not interfere with his ability to perform the job in Nigeria, and the job was the reliability engineering manager position?

A I agreed that he can do his job.

Q You agree that he could do his job?

A As a -- as a reliability engineer, but the location was the issue.

Q Exactly. So he could do the job. That's what I was asking. He could --

A Well, his job was in Escravos, which made it complicated.

Q Was Mr. Snookal able to perform the essential functions of his job, and that would have been the reliability engineering manager job?

A Yes.

Q That's the question. Yes? Thank you.

THE COURT: He answered.

BY MS. LEAL:

Q So the concern that you just expressed was that --

THE COURT: Give us a second.

BY MS. LEAL:

Q So the concern that you just expressed, Dr. Levy, was that if -- if Mr. Snookal had an aortic event in the future, the team in Escravos might require some sort of emergency response that they may or may not he about able to manage. Was that part of the concern?

A The concern was that if he had that event today, they were not equipped to handle that emergency.

Q What do you mean by "today"? Today at the time that he was in Escravos?

A If today was -- on his first day in Escravos. The risk would apply as soon as he was on -- as soon as he was on the ground.

Q So the concern was that if Mr. Snookal, the day he arrived in Escravos or the day after or two weeks later -- if, in the future, he had an aortic event, that's the reason you agreed with Dr. Asekomeh that he was not fit for duty; correct?

A I --

Q Yes or no, Dr. Levy. Is that correct or not?

A That sounds correct, yes.

Q Thank you.

C E R T I F I C A T E

MARK SNOOKAL :

vs. : No. CV 23-06302-HDV

CHEVRON USA, INC. :

I, MARIA BUSTILLOS, OFFICIAL COURT REPORTER, IN AND FOR THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA, DO HEREBY CERTIFY THAT PURSUANT TO SECTION 753, TITLE 28, UNITED STATES CODE, THE FOREGOING IS A TRUE AND CORRECT TRANSCRIPT OF THE STENOGRAPHICALLY REPORTED PROCEEDINGS HELD IN THE ABOVE-ENTITLED MATTER AND THAT THE TRANSCRIPT PAGE FORMAT IS IN CONFORMANCE WITH THE REGULATIONS OF THE JUDICIAL CONFERENCE OF THE UNITED STATES.

FEES CHARGED FOR THIS TRANSCRIPT, LESS ANY CIRCUIT FEE REDUCTION AND/OR DEPOSIT, ARE IN CONFORMANCE WITH THE REGULATIONS OF THE JUDICIAL CONFERENCE OF THE UNITED STATES.

_____/S/_____ 08/20/2025_

MARIA R. BUSTILLOS DATE
OFFICIAL REPORTER